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In The Supreme Court of the United States

JOHN P. WALTERS, ET AL.,

Petitioners,

v.

DR. MARCUS CONANT, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the court of appeals erred in affirming on First Amendment grounds a district court injunction that prevents federal officials from censoring non-criminal speech within the physician-patient relationship.

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OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

Respondents respectfully oppose the petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

In addition to the statutory provisions noted by Petitioners, this matter also involves the First Amendment to the United States Constitution.

STATEMENT OF THE CASE

1. As the trial court recognized, this case "is **not** about doctors prescribing, growing, or distributing marijuana," but rather "is about the ability of doctors, on an individualized basis, to give advice and recommendations to bona fide patients suffering from serious, debilitating illnesses regarding the possible benefits of personal, medical use of small quantities of marijuana." App. 76a (emphasis added). In short, the case concerns distribution of medical **information**, not distribution of drugs.

At issue are the First Amendment rights of physicians and patients. The challenged federal policy targets speech by forbidding any physician "recommendation" of marijuana – a term the government has construed so inconsistently and broadly as to censor any meaningful discussion of marijuana between a California physician and patient. Nothing in the injunction below hinders federal officials in

prosecuting a physician who violates criminal laws. What is extraordinary about the government's policy is that it suppresses physicians' legal, protected speech in an effort to influence the behavior of patients, hoping that censorship will dissuade patients from using marijuana. Federal officials have vast powers available to influence patient behavior, but the First Amendment ensures that suppression of protected speech is not among the options the government may employ.

2. For many years, federal officials voiced no opposition to the longstanding practice of physicians communicating to patients honest medical opinions concerning the relative risks and benefits of medical use of marijuana. Many physicians recommended marijuana as a medical matter, leaving patients to decide whether and how to implement physicians' advice. *See* C.A. SER 30-35 (1990 Harvard survey of more than 2,000 oncologists finding that 44 percent had recommended marijuana to cancer patients undergoing chemotherapy to control nausea or lack of appetite and majority would prescribe marijuana were it legal). Neither state nor federal regulators ever questioned the medical appropriateness of making such recommendations and never imposed any penalty on physicians who did so. The same has been true of many other remedies that, while not currently accepted as a pharmaceutical drug, are widely recommended – red wine to reduce the risk of heart disease, Vitamin C, acupuncture, or chicken soup, to name but a few.

Prior to the current controversy, federal policy concerning medical use of marijuana had two main components. First, federal law prohibits physician distribution of marijuana or issuance of prescriptions ordering a pharmacy to dispense marijuana to a patient. Prescription of

controlled substances is allowed only upon determination that the substance is "currently accepted" for medical use. 21 U.S.C. § 812(b)(1). As part of the original enactment of the Controlled Substances Act in 1970, Congress listed marijuana as a Schedule I substance having no currently accepted medical use. *See* 84 Stat. 1249.

The second component of federal marijuana policy involves government cultivation and distribution of marijuana to a small number of patients. Under the Compassionate Care program, the federal government took applications during the period 1978-1992 from patients whose physicians recommended marijuana. *See* App. 36a. Using marijuana cultivated by the federal government, "the government continues to supply individuals who participated in this program with marijuana under its Compassionate Care program; they are among the few people in the country who can use the drug legally." *Id.* Separately, federal officials supply marijuana for clinical trials in which physicians provide marijuana to patients for whom they believe it is medically appropriate. *See* App. 25a.

The contrast between a federal view of marijuana having no accepted medical use and federal officials supplying marijuana to patients is best explained by Judge Kozinski's observation in a concurring opinion below that there is a "legitimate and growing division of informed opinion on this issue." App. 21a. Judge Kozinski reviewed the considerable literature, including a recent, authoritative study commissioned by the federal defendants in this case, all finding support for some legitimate medical uses. This evidence and the widespread acceptance within the medical field, coupled with federal officials' current practice of supplying marijuana to patients,

demonstrate that physicians could honestly and legitimately view recommendation of marijuana as medically sound advice in some circumstances.

3. Respondents (plaintiffs below) represent classes of prominent and respected physicians and seriously ill patients. App. 47a. The nine named physician plaintiffs include Dr. Marcus Conant, who directs a large private HIV/AIDS practice, a group of physicians with responsibility for primary care of over 5,000 persons infected with HIV, including approximately 2,000 patients with active AIDS. *See* App. 47a. Dr. Conant is the author or co-author of more than 70 publications on the treatment of AIDS. C.A. SER 56 (Conant Declaration, ¶ 5). Dr. Neil Flynn is a Professor of Clinical Medicine in the Division of Infectious Diseases at the University of California at Davis School of Medicine, an attending physician in the University Medical Center's AIDS and Related Disorders Clinic where he participates in the care of some 1,500 AIDS patients, and the author of numerous publications on infectious diseases. C.A. SER 90, 91 (Flynn Declaration, ¶¶ 1, 5). Dr. Debasish Tripathy specializes in treating breast cancer and actively conducts research and publishes studies concerning breast cancer treatment. C.A. SER 141 (Tripathy Declaration, ¶¶ 2, 3).

The six patient plaintiffs "suffer from horrible disabilities" and diseases. App. 28a. Plaintiff Judith Cushner, the director of a pre-school program and a mother of two, "has fought breast cancer since 1989" and "only found relief from the debilitating effects of chemotherapy by smoking cannabis to counteract nausea, retching and chronic mouth sores." *Id.* In the face of the devastating side effects of chemotherapy, she considered discontinuing treatment, even though it could have proven fatal. With

success in using marijuana to relieve her symptoms, she was able to tolerate and complete her chemotherapy regimen. *See* C.A. SER 75-76 (Cushner Declaration, ¶¶ 10, 12). Plaintiff Keith Vines is "an Assistant District Attorney, decorated Air Force officer and father, whose bout with AIDS had caused him to lose more than 40 pounds of lean body mass." App. 28a. "His bones became brittle and his joints, for lack of nourishment, ached." App. 48a. His many medications suppressed his appetite. "Not only did Mr. Vines need food to stave off AIDS wasting syndrome, but his experimental growth-hormone therapy required that he eat regularly." *Id.* After failing to respond to other medications and with great reluctance given his career in law enforcement, he decided, based on information from two of his physicians, to obtain and use small amounts of cannabis. *See* App. 49a. His appetite increased, the hormone therapies became effective, and he returned to his normal, healthy body mass. He "credits medical marijuana with helping to save his life." App. 48a.

4. With passage of a ballot initiative entitled "the Compassionate Use Act," the people of California "adopted a narrow exemption from their laws prohibiting the cultivation, sale and use of marijuana." App. 21a. This exemption is available only to seriously ill persons who have received the "recommendation" or "approval" of a physician for the medical use of marijuana. Cal. Health & Safety Code § 11362.5(d). Under the Act, a "recommendation" does not provide a means to obtain marijuana and does not authorize or cause the distribution of marijuana under State law.

A recommendation is **not** a prescription. A physician's recommendation is the means of drawing on the physician's judgment, knowledge, and experience, all in order to

communicate advice that the physician believes is the best balance of risks and benefits for an individual patient. Patients are free to follow or ignore the advice, but the advice itself does not authorize or cause the distribution of a drug. A prescription, by contrast, is an order directing a pharmacy to dispense a particular drug. Petitioners point out that one private entity in Oakland, California, has independently decided to ask patients to present, not a "recommendation," but a physician statement "assenting to marijuana therapy" before dispensing marijuana. Pet. for Cert. at 20. California law does not contemplate the existence of any marijuana distribution entities and sets no standards or rules for such entities in selecting clientele. The so-called buyers' clubs operate "[a]s independent entities, [and] each distribution center has developed and modified its own criteria," and "many do not require that the physician recommend medical marijuana." C.A. SER 616 (Expert Report of Dr. Herminia Palacio).

Although a physician "recommendation" of marijuana serves no special role in obtaining marijuana, a patient may decide to utilize a physician's medical advice as a means of establishing the patient's exemption from state law prosecution. The State chose to differentiate medical from non-medical use based on the judgment of state-licensed physicians. The State equally could have decided to exempt marijuana use that an individual merely claims is medical or marijuana use for all persons diagnosed with particular diseases (and such measures could yet be enacted), but the State instead selected a more narrow exemption applicable only to patients whose medical needs are verified by the profession best able to render such judgments.

The Compassionate Use Act itself does not permit physicians to prescribe marijuana or otherwise assist in its acquisition. Rather, the statute recognizes that physicians have traditionally provided patients with their best medical judgments about marijuana use – either approving it or counseling against its use, depending on the individual circumstances of a patient. State law looks to these traditional judgments to determine whether use of medical marijuana is punishable under California's criminal law. No physician is required to render advice about marijuana, but a physician may choose to do so, in the context of a proper doctor-patient relationship and in a manner that conforms to the professional standards of the community.

In response to enactment of the Compassionate Use Act, which federal officials saw as undermining their message on drugs, the government announced a policy stating, for the first time, that the longstanding practice of doctors recommending medical marijuana would now lead to revocation of DEA registrations (that is, physicians' licenses to prescribe controlled substances). *See* App. 119a-120a. Federal officials did not claim that federal law preempts or otherwise supplants State law: California is free to exempt marijuana use by some or all of its citizens from its criminal law. Federal officials also never claimed that rendering advice (even approvals or recommendations) concerning marijuana had been a violation of federal law prior to enactment of the Compassionate Use Act or that such advice now violates federal law when rendered in states with no state-law exemption for medical marijuana. Rather, federal officials took the view that enactment of the Compassionate Use Act, with the new legal operative effect given to a physician recommendation

under State law, transformed medical advice into a violation of federal law, even when the physician had no intention of doing anything other than providing the patient with the same honest medical counsel as before the Act. The policy treats advice as if it were the drug itself, blurring the distinction between information and a prescription.

5. Federal threats against physicians had an immediate and devastating effect. Revocation of federal physician licenses, necessary for a physician to be able to prescribe drugs, is accomplished through a DEA administrative procedure. *See* 21 U.S.C. § 824(c). Upon a showing that a physician's discussion of marijuana with a patient was a "recommendation," the physician's career would effectively be ended. Given the lack of any definition or explanation of the term "recommendation," physicians could only protect their livelihood and reputation by avoiding the subject of marijuana altogether. The court of appeals noted that "the record is replete with examples of doctors" who have been chilled in explaining medical marijuana to their patients. App. 17a.

As the district court found and Petitioners stipulated, physicians' fear of license revocation was reasonable. App. 59a. The federal policy stated unequivocally that physicians' "action of recommending [marijuana] will lead to administrative action by the Drug Enforcement Administration to revoke a practitioners' registration." App. 119a-120a. The district court pointed out that this "warning appears serious," given that "during the short period between issuances of the Administration's Response and the preliminary injunction, a DEA agent interviewed" and requested pharmacy records from a California physician who had done nothing more than recommend marijuana

on one occasion. App. 56a. Petitioners further stipulated that physicians have reacted to the Administration's Response by censoring their conversations with patients and withholding information, recommendations, or advice regarding use of medical marijuana. C.A. ER 180-81 (Joint Statement of Undisputed Facts, ¶ 11).

The consequences of physicians' self-censorship in the face of government intimidation were documented in detail below in the Brief of *Amici* California Medical Association, *et al.* In short, many patients' discussions with their physicians are the primary or only source of sound medical advice and information. C.A. ER 182 (Joint Statement of Undisputed Facts, ¶ 17). As plaintiff physician Stephen O'Brien puts it, for patients "in the advanced stages of a life-threatening illness, information [a physician] can provide about medical marijuana can mean the difference between life and death." C.A. SER 133-34 (O'Brien Declaration, ¶ 9). Among the undisputed consequences of the Administration's Response is that it has caused some physicians to omit medically relevant information from patient medical records. C.A. ER 181 (Joint Statement of Undisputed Facts, ¶ 13). It is undisputed that maintaining accurate charts is necessary to provide sound medical care to patients, and the failure to do so could jeopardize the patient's life and health. C.A. ER 182 (Joint Statement of Undisputed Facts, ¶ 19).

6. Plaintiffs filed this lawsuit to seek protection for California physicians from federal retaliation for providing candid advice to patients about the medical use of marijuana. In order to remedy the chilling effect on free speech and the harm to medical care caused by the government's threats, plaintiffs sought a preliminary injunction. After first issuing a temporary restraining order *sua sponte*, the

district court entered a preliminary injunction. App. 74a-115a. In so doing, the court stressed that the government has "done nothing to demonstrate that there is anything more than the weakest link between non-criminal physician-patient dialogue and the government's ability to enforce federal laws." App. 106a. The court accordingly entered a preliminary injunction protecting doctors who engage in non-criminal speech. App. 114a.

Plaintiffs then sought and obtained a permanent injunction on summary judgment. App. 40a-73a. The district court rejected the government's construction of the Controlled Substances Act, relying on extensive First Amendment analysis that showed "serious constitutional doubts" in a construction that permitted DEA to revoke a physician's registration based solely on a recommendation of marijuana. App. 53a, 64a-73a. Accordingly, the district court permanently enjoined the government "from (i) revoking a class-member physician's DEA registration merely because the doctor recommends medical marijuana to a patient based on a sincere medical judgment and (ii) from initiating any investigation solely on that ground." App. 73a. Like the preliminary injunction, the permanent injunction leaves the government ample power to punish a doctor who violates the law. *See* App. 72a.

The court of appeals affirmed the district court's permanent injunction, not as a matter of statutory construction, but under well-established First Amendment principles. App. 1a-39a. In so doing, the court did not strike down a statute, but instead addressed a federal policy. App. 3a. The court of appeals dismissed the government's attempt to equate protected "recommendations" of medical marijuana with forbidden "prescriptions." App. 9a. The court then found that a physician cannot be held

criminally responsible based on the "anticipation of patient conduct" that is illegal. App. 10a-11a. The court of appeals also dismissed the government's argument that the permanent injunction improperly interfered with the government's investigative discretion, finding that investigations are permitted if "the government in good faith believes that it has substantial evidence of criminal conduct." App. 11a-12a. The court below then found that the government's policy was deficient on First Amendment grounds. The policy "strike[s] at core First Amendment interests of doctors and patients." App. 12a. In particular, the court of appeals recognized the importance of communication between a physician and a patient, based on established Supreme Court precedent. *See* App. 12a-14a. The court of appeals ruled that the government's policy "seeks to punish physicians on the basis of the content of doctor-patient communications," and indeed "condemns expression of a particular viewpoint." App. 14a. The court further found that the policy violated the First Amendment on vagueness ground, since "the government has been unable to articulate exactly what speech is proscribed," leaving it dependent on the meaning a patient gives to the doctor's speech. App. 17a. The result is that "'when faced with the fickle iterations of the government's policy, physicians have been forced to suppress speech that would not rise to the level of that which the government constitutionally may prohibit.'" App. 17a-18a (quoting preliminary injunction opinion). Finally, the court of appeals found that "the injunction is not intended to limit the government's ability to investigate doctors who aid and abet the actual distribution and possession of marijuana." App. 3a.

Judge Kozinski concurred, stressing the importance of the injunction to patients who need medical information. *See* App. 18a-20a. The concurrence notes that a "number of health care professionals and organizations have concluded that the use of marijuana may be appropriate for a small class of patients." App. 21a. Although there is no definitive proof, "there is a genuine difference of expert opinion on the subject, with significant scientific and anecdotal evidence supporting both points of view." App. 26a. For patients with serious illnesses, "information obtained from chat rooms and tabloids cannot make up for the loss of individualized advice from a physician with many years of training." App. 28a.

After the court below affirmed the permanent injunction, the government filed a petition for rehearing and petition for rehearing *en banc*, which the court of appeals denied without a request for an *en banc* vote by Order of February 6, 2003. App. 116a-117a.

REASONS FOR DENYING THE PETITION

The decisions below by two district court judges and a unanimous appellate panel all follow established law in finding that the First Amendment protects communications between physicians and their patients from government censorship. Review by this Court is unnecessary for three reasons. First, the decision below creates no conflict among the circuits and no future conflict is likely. Second, the decision does not interfere with federal law enforcement authority. The injunction issued below is limited to protecting the rights of patients and physicians to communicate about marijuana. Physician speech conveys

information, but this is different from distribution of marijuana itself. Federal officials retain full authority to act against any physician effort to distribute marijuana. Third, the decision below was correct.

1. The opinion below arose out of an extraordinary set of circumstances in California and is *sui generis*. The decision below creates no conflict among the circuits and is unlikely to do so in the future. At issue in this case is a federal policy that, by its very title, is geographically limited: The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200. *See* App. 118a. The portion of the policy enjoined below – revoking the registration of physicians who "recommend" marijuana, App. 120a – relates only to California. Among the other states that have created medical marijuana exemptions, all but two are in the Ninth Circuit. *See* Pet. for Cert. at 6 n.3. Petitioners emphasize that their policy did not provide any "guidance on what physicians in diverse settings throughout the Nation should or should not say about marijuana." *Id.* at 24. The government has not sought to expand its policy to reach these other states. In sum, this is a unique case that arises out of the federal government's response to California's law. No disagreement exists among the courts of appeals on the issues raised in this case, and no disagreement appears likely to emerge in the future.[1]

[1] Another challenge to the government's policy was dismissed in *Pearson v. McCaffrey*, 139 F. Supp. 2d 113 (D.D.C. 2001), but not appealed. The court in that case failed to recognize that recommendations of marijuana constitute speech and, as opposed to prescriptions, are not orders to dispense drugs. *See id.* at 121.

2. In arguing that this case is of exceptional importance, Petitioners mischaracterize and misunderstand the scope of the injunction below, claiming that it prevents "the federal government from exercising its statutory authority" over controlled substances. Pet. for Cert. at 14. Petitioners cite four specific areas of concern, none of them justified upon examination of the ruling and the record below.

a. This is not a case involving invalidation of an Act of Congress. To the contrary, the court below invalidated a **policy** that both violates the First Amendment and is not authorized by statute. An injunction against *ultra vires* executive action does not amount to striking down an Act of Congress.

Petitioners elide a critical distinction: the federal Controlled Substances Act concerns distribution of drugs, while each state is responsible for ensuring that physicians adhere to the standard of medical care within its own jurisdiction.[2] The decision below does not intrude on federal statutes restricting controlled substances. The court below observed: "The history of the litigation

[2] State medical boards, as well as state law tort claims for malpractice, stand as the fundamental guarantors that medical practice meets an appropriate standard of care. A physician who recommends or advises an unreasonably dangerous treatment or otherwise acts outside of the state's established practice guidelines can be punished. Petitioners' invocation of a slippery slope leading to recommendation of heroin or LSD is entirely fanciful, as state regulatory mechanisms prevent such dangerous advice. The federal government, however, has never before claimed the authority to regulate the practice of medicine beyond **distribution** of controlled substances. Advice and recommendations fall within the states' power, and they have proved entirely able to ensure a standard of care that will protect patients.

demonstrates that the injunction is not intended to limit the government's ability to investigate doctors who aid and abet the actual distribution and possession of marijuana." App. 3a (citing 21 U.S.C. § 841(a)). Judge Kozinski concurred in this conclusion, pointing out:

> This is not a situation like *United States v. Moore*, 423 U.S. 122 . . . (1975), where a doctor used his prescriptions license to circumvent the federal drug laws. Moore conducted inadequate or no medical examinations, ignored the results of the few tests he did perform, prescribed however many tablets the 'patient' asked for and graduated his fee according to the number he prescribed. *See id.* at 142-43. . . . The Court concluded that Moore had abandoned his professional role and effectively become a drug dealer. Here, by contrast, doctors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. . . . [D]octors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine. The doctor-patient relationship is an area that falls squarely within the states' traditional police powers.

App. 33a-34a. In sum, federal drug laws remain intact: DEA retains its statutory ability to revoke the federal license of a physician upon demonstrating in an

administrative or criminal proceeding that the physician has violated laws regarding distribution of drugs.[3]

b. Just as the federal drug statutes remain undisturbed, the ruling below does not interfere with the ability of federal officials to enforce those statutes. The district court found: "The government has not pursued any criminal prosecutions in the years since the Administration's Response, despite the clear authority under Judge Smith's preliminary injunction allowing prosecutions for conspiracy and aiding and abetting. Nor had the government pursued any prosecutions before the preliminary injunction." App. 58a. As the court of appeals found, Petitioners have "not provided any empirical evidence to demonstrate that this injunction interferes with or threatens to interfere with any legitimate law enforcement activities. Nor is there any evidence that the similarly phrased preliminary injunction that preceded this injunction . . . , which the government did not appeal, interfered with law enforcement." App. 3a. If there were unintended consequences of the injunction, the proper response would be to present the district court with evidence and seek to modify the injunction, not to request review in this Court based on a record that discloses no interference with legitimate law enforcement objectives. Petitioners' argument concerning limitations on federal law enforcement authority ends up resting on the most abstract speculation.

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[3] Just as the injunction here leaves federal drug laws intact, it also poses no conflict with this Court's decision in *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001), which upheld the supremacy of federal law in prohibiting dispensing of marijuana upon a claim of medical necessity. *See* App. 7a.

c. Petitioners provide no basis for the fanciful assertion that the decision below "effectively licensed physicians to treat patients with prohibited substances." Pet. for Cert. at 14. Petitioners insinuate that physicians somehow provide marijuana to patients, a course of action that all agree would be subject to federal punishment. Far from "treating" patients with marijuana, physicians merely provide patients with honest information and advice.

d. The injunction below relies on the First Amendment to include a specific, limited restriction on federal investigations. As explained by the court of appeals: "The permanent injunction order enjoins the government 'from initiating any investigation **solely on**' the basis of 'a recommendation for the use of medical marijuana based on a sincere medical judgment.' ... The preliminary injunction order provided that 'the government may not take administrative action against physicians for recommending marijuana unless the government in good faith believes that it has substantial evidence of [conspiracy or aiding and abetting].'" App. 11a (emphasis added). The court continued: "Because we read the permanent injunction as enjoining essentially the same conduct as the preliminary injunction, we interpret this portion of the permanent injunction to mean only that the government may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship, unless the government in good faith believes that it has substantial evidence of criminal conduct. Because a doctor's recommendation does not itself constitute illegal conduct, the portion of the injunction barring investigations solely on that basis does not interfere with the federal government's ability to enforce its laws." *Id.* at 11a-12a.

Under the permanent injunction, therefore, federal officials retain their authority to investigate physician conduct for violations of federal law, but physician advice **alone** cannot serve as the basis for subjecting physicians to an investigation that will, by its very existence, chill physicians from engaging in protected speech that runs contrary to the government's own viewpoint on the appropriate use of marijuana.

The lower court exercised its equitable discretion in crafting a remedy that narrowly addresses the special circumstances of this case. Federal officials made explicit, repeated threats against law-abiding doctors. *See, e.g.*, C.A. SER 778 (interview with ONDCP Director Barry McCaffrey), 720 (statement of DEA Administrator Thomas Constantine). The threats included the possibility of extraordinary investigatory intrusions into the privacy of the medical examination room, including use of informants, undercover agents posing as patients, and covert surveillance to monitor physician advice. *See* C.A. SER 775 (article reporting planned use of these tools); *see also* C.A. SER 630-31 (Expert Report of Joseph McNamara); App. 102a. Given the tenuous line the government has drawn between a forbidden recommendation and a permissible discussion of marijuana, the prospect of aggressive investigation inspired fear and self-censorship among physicians. Most physicians avoided any discussion of marijuana at all given the prospect of federal agents listening in to parse every word as possibly straying into the undefined realm of forbidden recommendations. A narrow injunction against investigations based solely on protected speech is necessary to protect the First Amendment rights of physicians and patients, while the intrusion

upon government power is hypothetical and, at most, very limited.

3. The court of appeals correctly ruled that the federal policy at issue here violates the First Amendment by forbidding physician speech that recommends medical marijuana. The government has adopted a policy that targets protected speech in order to suppress a message with which it disagrees. The policy is unconstitutionally vague because a person of reasonable intelligence could not determine what speech is permitted. The physicians who are supposed to follow the policy are completely confused by what it prohibits, and government officials cannot explain its meaning. In the face of this confusion, with their very livelihoods at stake, physicians are chilled from the mere mention of marijuana to patients. The government has a variety of means to pursue its legitimate policy aims, but the First Amendment prevents it from doing so by limiting speech based on the viewpoint being expressed and by a means so vague as to be incomprehensible.

a. The government policy at issue here restricts speech by a physician to a patient concerning a topic of mutual, pressing concern. Physicians are threatened with career-ending consequences if they speak words the government has forbidden. Patients are unable to hear their physicians' communications because of government censorship. No matter how Petitioners seek to characterize the governmental interest, it is undeniable that their selected means of pursuing that interest is through suppression of speech. As such, this case is fundamentally, unavoidably about the First Amendment.

The court of appeals explained the particular value of speech between physician and patient, observing that an "integral component of the practice of medicine is the communication between a doctor and a patient. Physicians must be able to speak frankly and openly to patients." App. 12a. The California Medical Association argued as an *amicus curiae* below that the nation's history and tradition demonstrate an unswerving recognition of the sanctity of physician-patient dialogue. *See also Trammel v. United States*, 445 U.S. 40, 51 (1980) (discussing doctor-patient and lawyer-client testimonial privileges and noting they are "rooted in the imperative need for confidence and trust"). The highly personal and often controversial nature of medical information creates a vulnerability to government-imposed orthodoxy concerning information and advice that a physician provides a patient. That the federal government considers marijuana not to have a sufficiently accepted medical use to allow for its prescription does not change the rights of doctors to express a contrary view and of patients to hear a contrary view from their physicians. While agreeing in his concurrence that physician speech is imperiled by the federal policy, Judge Kozinski emphasized the cost to patients of physician censorship: "Those immediately and directly affected by the federal government's policy are the patients, who will be denied information crucial to their well-being." App. 19a-20a.

Whether viewed from the perspective of physician or patient rights, the First Amendment applies to the speech at issue. This Court has recognized that physician speech receives First Amendment protection because of the significance of the doctor-patient relationship. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505

U.S. 833, 884 (1992) (plurality opinion) (recognizing physician's First Amendment right not to speak); *Rust v. Sullivan*, 500 U.S. 173, 200 (1991) (noting that regulations on physician speech may "impinge upon the doctor-patient relationship"). Patients' right to hear – the right to receive information – is no less protected by the First Amendment than physicians' right to convey information. *See Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 756-57 (1976).

As the Court noted recently in an analogous context, the extensive regulation and even funding of Legal Services attorneys does not justify restricting the advice they can provide clients. *See Legal Services Corp. v. Velazquez*, 531 U.S. 533 (2001). The general concerns raised when government pursues its policy goals through restrictions on speech are made all the more acute when the government inserts itself into a relationship that depends on effective communication. Similar to the government's restrictions on attorneys' speech in *Velazquez*, the federal policy here "alter[s] the traditional role" of physicians by "prohibiting speech necessary to the proper functioning" of the medical profession. *Id.* at 544.

Most recently, this Court recognized that physician speech concerning controlled substances – even in the context of proposing a commercial transaction – is protected by the First Amendment. *Thompson v. Western States Medical Ctr.*, 535 U.S. 357 (2002). The court of appeals addressed that case as follows:

> The Court refused to make the "questionable assumption that doctors would prescribe unnecessary medications" and rejected the government's argument that "people would make bad decisions if given truthful information about compounded

> drugs." *Id.* at 1507. The federal government argues in this case that a doctor-patient discussion about marijuana might lead the patient to make a bad decision, essentially asking us to accept the same assumption rejected by the Court in *Thompson*. *Id.* We will not do so. Instead, we take note of the Supreme Court's admonition in *Thompson*: "If the First Amendment means anything, it means that regulating speech must be a last – not first – resort. Yet here it seems to have been the first strategy the Government thought to try." *Id.*

App. 14a.

b. The government's ban on physician "recommendation" of medical marijuana, coupled with its position that physicians are free to "discuss" marijuana, *see* Pet. for Cert. at 8, is so vague as to be unintelligible. The government's policy suffocates physician speech by failing to distinguish between permissible "discussions" and forbidden "recommendations" with the narrow specificity the Constitution requires. Originally, the government's official policy flatly stated that "recommending . . . [marijuana] will lead to administrative action," without defining the term "recommend" at all. App. 119a. The government then issued a letter that pointedly omitted reference to the critical term "recommendation," while stating that a physician may "discuss[ ] with a patient the risks and alleged benefits of the use of marijuana," but "may not intentionally provide their patients with oral or written statements in order to enable them to obtain [marijuana] in violation of federal law." App. 130a-131a. The official most responsible for the policy, ONDCP Director McCaffrey, admits that he is "still puzzling" over the status of a recommendation, is "not sure what any of it

means," and is "not sure in isolation I know what a recommendation is." C.A. SER 441-42, 443-44, 451 (deposition transcript).

The recent interpretations of the policy provided by the government have been broad and vague. In opposing summary judgment, the government defined a forbidden "recommendation" as follows: "Where a physician advises, counsels, suggests, or 'urges as advisable or expedient' that a patient use marijuana for medical treatment, or presents marijuana 'as worthy of confidence, acceptance, use, etc.,' the physician has recommended marijuana." C.A. SER 788. The breadth of this definition is so staggering that it requires the conclusion that physicians have been compelled to avoid discussion of marijuana. Can a physician say "the benefits of marijuana outweigh the risks" – or does this stray into the forbidden zone of presenting marijuana as "worthy of use"? Can a physician say that anecdotal evidence suggests that marijuana can sometimes alleviate nausea – or does this "suggest" that marijuana use is "expedient"? In light of the government's sweeping prohibition, one struggles to imagine permissible "discussions" other than those parroting the federal view that marijuana can never serve any patient's medical needs.

In this Court, the government ignores its earlier broad and vague definitions of "recommendation." But even at this late date, the government fails to provide a reasonably clear definition of what physician speech will lead to revocation proceedings. At one point, the government states that a "physician who genuinely wishes to express his opinion to a patient regarding marijuana" may do so, but only upon following a scripted formula that the government has never before articulated in the more than six

years since announcing its policy: the physician must (1) "warn his patient" that marijuana is illegal under federal law; (2) inform the patient that Congress has concluded that marijuana has a high potential for abuse, no currently accepted medical use in treatment, and a lack of accepted safety; and (3) "advise the patient that the physician's comments about marijuana are not to be considered a recommendation or approval of the use of marijuana" except through federally approved programs. Pet. for Cert. at 22. Even if a physician follows this latest of many lawyer-generated articulations of government policy, the risk of punishment remains, though such consequences are deemed "extraordinarily unlikely." *Id.*

This position is simply not coherent. On the one hand, the government maintains that marijuana can never be medically appropriate, and that a physician who says differently to a patient will be punished. On the other hand, the government admits that a physician can recommend marijuana, so long as the physician states that it is not a "recommendation" for purposes of California law.[4] At every juncture in this litigation, the government has been unable to articulate a consistent explanation of the line between protected speech and forbidden recommendations, resulting in a hodgepodge of positions the district court described as "fickle iterations." App. 103a. Far more workable and far less restrictive of speech is the line that

[4] Inclusion of federally imposed disclaimers ("my recommendation of marijuana is not a recommendation") does not operate to limit California law. California is free to find an exemption from its own criminal laws for a patient whose physician substantively approves or recommends marijuana. The form of that statement does not control such exemption.

has long existed and that forms the basis of the injunction – the line between physicians providing medical information as opposed to criminally participating in distribution of marijuana.

Petitioners seem to take the position that the permissibility of a physician's speech turns on whether it is treated by the patient or by the State of California as a "recommendation" that creates exemption from state criminal law. But the First Amendment requires that policies restricting protected speech must clearly delineate what a speaker is forbidden from communicating without being contingent upon the meaning inferred by an audience or those charged with enforcing a policy. Directly controlling on this point is *Thomas v. Collins*, where the Court struck down on vagueness grounds a statute restricting "solicitation" of workers for membership in a labor union. The Court observed that the protected speech of advocating generally that workingmen should "unite for collective bargaining," even while avoiding the words "'solicit,' 'invite,' [and] 'join,'" could not possibly avoid the idea of solicitation. 323 U.S. 516, 534 (1945).

> [T]he supposedly clear-cut distinction between discussion, laudation, general advocacy, and solicitation puts the speaker in these circumstances wholly at the mercy of the varied understanding of his hearers and consequently of whatever inference may be drawn as to his intent and meaning. Such a distinction offers no security for free discussion.

Id. at 535.

The blurred distinction here between discussion and recommendation in the government's license revocation

policy impermissibly places physicians in the same untenable position as the union official in *Thomas*. No physician could safely assume that a statement ("marijuana appears beneficial for you" or "marijuana is the most effective substance I am aware of to relieve your symptoms") would not be understood by a patient (or an undercover DEA agent posing as a patient) as a prohibited "recommendation," leading to investigation and license revocation. The "supposedly clear-cut distinction" between discussion of marijuana and recommendation puts the physician wholly at the mercy of the varied understanding of others, predictably resulting in physician self-censorship.

c. The government's restriction on speech in this case turns on the content of a physician's communication. The court of appeals found that "the policy does not merely prohibit the discussion of marijuana; it condemns expression of a particular viewpoint, i.e., that medical marijuana would likely help a specific patient." App. 14a. A physician who states the opinion that marijuana is not advisable for a particular patient risks no federal punishment because the recommendation conforms to the government-dictated viewpoint. In contrast, the government has stated that it will revoke the DEA registration of a physician who communicates a genuine, well-founded belief that, for instance, marijuana might relieve the unremitting nausea of a patient undergoing chemotherapy.

A ban on communicating particular views creates grave First Amendment concerns. All content-based restrictions on speech are "presumptively invalid." *R.A.V. v. St. Paul*, 505 U.S. 377, 382 (1992). "When the government targets not subject matter but particular views taken by speakers on a subject, the violation of the First

Amendment is all the more blatant." *Rosenberger v. Rector*, 515 U.S. 819, 829 (1995).

Federal officials have long sought to promote the federal viewpoint that marijuana has no medical use, all in the belief that the public is less likely to use marijuana if it accepts the government view. The government now has gone the next, impermissible step of seeking to impose a uniformity of viewpoint by silencing physicians who disagree with government policy because it could "promote illegal drug use." Pet. for Cert. at 16. The government's desire to influence patient conduct by eliminating opposing viewpoints is not permissible merely because the speaker receives a government license. The government invokes *Gentile v. State Bar of Nevada*, 501 U.S. 1030 (1991) as authority for dictating what physicians can and cannot say to patients. There, the Court evaluated a content neutral limitation on the statements of attorneys participating in trials by balancing the judiciary's interest, grounded in the Constitution itself, in the operation of the court system – an interest that was viewed in the context of courts' longstanding history of regulating the practice of law – against the First Amendment rights of attorneys to speak to the press. Here, in contrast, the federal government's interest in imposing its own viewpoint upon the content of physician speech has no grounding in regulating the practice of medicine – a function that has long been the province of the states, not the federal government – but in attempting to control the conduct of patients who might decide to acquire or use drugs.

d. The Controlled Substances Act does not authorize the policy challenged here. Petitioners rely upon a single provision of the Act that allows for revocation of physician DEA registrations based on "other conduct that may

threaten the public health and safety." 21 U.S.C. § 823(f)(5). Petitioners propose an extraordinarily expansive reach for this catch-all language, authorizing DEA to impose its judgment upon virtually every aspect of medical practice, despite a long history leaving "states as the primary regulators of [medical] professional conduct." App. 18a (citing *Whalen v. Roe*, 429 U.S. 589, 603 n.30 (1977); *Linder v. United States*, 268 U.S. 5, 18 (1925)). DEA's ambitious construction of its authority is contradicted by the broader text, structure, and legislative purpose of the physician-licensing provisions of the Controlled Substances Act, all of which uniformly concern physician distribution and diversion of controlled substances, not regulation of a physician's advice or other aspects of medical practice.

The title of the 1984 amendment that added the "public health and safety" ground for license revocation shows that Congress aimed specifically at preventing physicians diverting prescription drugs from medical to non-medical use – not some broader agenda of regulating the content of physicians' medical advice. *See* Dangerous Drug Diversion Control Act, P.L. 98-473, 98 Stat. 2070. The amendment sought to address "prescription drugs [being] diverted by legitimate medical distributors to the illicit drug market," and so sought expanded authority to punish physicians "who **write or dispense prescriptions** in a way that is threatening to the public health or safety." 130 Cong. Rec. H9681 (daily ed. Sept. 18, 1984) (remarks of Rep. Gilman) (emphasis added). Federal regulation of physician prescription licenses "under the Controlled Substances Act is a matter **entirely separate from a physician's State license to practice medicine.**" Legislative History, S. Rep. No. 225, 98th Cong., 2d

Sess., *reprinted in* 1984 U.S.C.C.A.N. 3182, 3449 n.40 (emphasis added). To the extent that the federal government is concerned with the overall practice of medicine, the government "will continue to give deference to the opinions of the State licensing authorities." *Id.* at 3449.

The expansive claim for DEA's regulatory power also collides with the doctrine of constitutional doubt. *See* App. 72a-73a. Given the serious constitutional questions raised by Petitioners' policy, the district court properly rejected Petitioners' invitation to stretch the language creating DEA's authority to govern "conduct that may threaten the public health and safety" so as to include restrictions on physicians' non-criminal speech. Petitioners can point to no hint of Congressional intent to control physicians' medical advice – a matter that properly rests with state licensing boards that are fully equipped to protect patients from dangerous or improper recommendations.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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